Supreme Court, U.S.
FILED
JAN 4 - 2016
OFFICE OF THE CLERK

No. 15-274

IN THE

Supreme Court of the United States

WHOLE WOMAN'S HEALTH, ET AL.,
Petitioners,

v.

KIRK COLE, M.D., COMMISSIONER OF THE TEXAS DEPARTMENT OF STATE HEALTH SERVICES, ET AL.,
Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

BRIEF OF PHYSICIANS FOR REPRODUCTIVE HEALTH AS *AMICUS CURIAE* IN SUPPORT OF PETITIONERS

Thomas M. Bondy
Susannah Landes Weaver
ORRICK, HERRINGTON & SUTCLIFFE LLP
1152 15th Street, NW
Washington, DC 20005

E. Joshua Rosenkranz
Counsel of Record
Sarah M. Sternlieb
ORRICK, HERRINGTON & SUTCLIFFE LLP
51 West 52nd Street
New York, NY 10019
(212) 506-5000
jrosenkranz@orrick.com

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INTEREST OF *AMICUS*[1]

Physicians for Reproductive Health is a doctor-led nonprofit that seeks to assure meaningful access to comprehensive reproductive health services, including contraception and abortion, as part of mainstream medical care. Founded in 1992, the organization currently has over 6,000 members across the country, including over 3,000 physicians who practice in a range of fields: obstetrics and gynecology, pediatrics, infertility, family medicine, emergency medicine, cardiology, public health, neurology, radiology, and more. These members, many of whom provide abortion care, include faculty and department heads at academic medical centers and top hospitals. Thousands of physicians have participated directly in the group's training and education activities, and many more rely on the medical resources that the group produces.

In public discussions of reproductive health care, Physicians for Reproductive Health seeks to share the physician's distinctive voice, expertise, and experience. To that end, the group has long gathered and published stories of doctors who provide reproductive health services. It features some of these written and video accounts on its website, http://prh.org/provider-voices/.

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[1] The parties have consented to the filing of this *amicus* brief. No counsel for a party authored the brief in whole or in part. No party, counsel for a party, or any person other than *amicus* and their counsel made a monetary contribution intended to fund the preparation or submission of the brief.

Abortion restrictions like the ones at issue in this case directly impact the physicians the group represents, significantly constraining their ability to provide sought-after medical care. While defenders of such restrictions frequently resort to myths and misconceptions about abortion providers, Physicians for Reproductive Health can attest that these providers are, in reality, consummate professionals, as highly trained and deeply committed to their work as their colleagues in other medical specialties. These providers know better than anyone the true consequences of unduly restrictive abortion regulations. They are gravely concerned that, despite being framed as health-protective measures, Texas's laws and similar enactments needlessly jeopardize women's health.

INTRODUCTION AND SUMMARY OF ARGUMENT

Medical professionals play a "central role" in this Court's abortion jurisprudence. *Colautti v. Franklin*, 439 U.S. 379, 387 (1979). *Roe v. Wade*, 410 U.S. 113 (1973), and its progeny establish a woman's right to end her pregnancy *with assistance from her physician*. Indeed, a chief virtue of this Court's decisions has been to bring abortion out of the shadows, allowing women to obtain safe care from qualified providers. Texas's onerous regulations (and others like them) restrict women's access to exactly the sort of highly trained, experienced, and ethical physicians who ought to be delivering care under this Court's precedents. In so doing, the regulations threaten the health of the very women they purport to protect, while doing nothing to improve safety. That is unlawful. Respecting a woman's reproductive autonomy

necessarily means allowing her to obtain the services of willing physicians "free from unwarranted governmental intrusion." *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 875 (1992) (quoting *Eisenstadt v. Baird*, 405 U.S. 438, 453 (1972)).

This brief addresses Texas's admitting privileges and ambulatory surgical center (ASC) requirements from the perspective of physicians who provide abortions. It combines conventional legal argumentation with first-person narratives from abortion providers themselves.[2] The providers' powerful and poignant reflections help to demonstrate why Texas's laws are so extraordinarily problematic and so completely contrary to the principles that this Court recognized in *Roe* and reaffirmed in *Casey*. The brief offers two core arguments:

I. To the extent that Texas's drastic restrictions on abortion-providing physicians reflect a belief that such physicians are subpar caregivers whose work imperils women's health, they are fundamentally misguided. Physicians who provide abortions are highly trained and have a long track record of delivering care that is extremely safe in both absolute and relative terms. They have chosen to offer abortion services precisely because they are profoundly committed to women's health and well-being.

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[2] The narratives were compiled from interviews conducted by Physicians for Reproductive Health and *amicus* counsel. The physicians each personally reviewed and approved the versions of their accounts that appear herein. The opinions expressed are their own, and are not necessarily shared by the institutions for which they work.

Some remember all too vividly the deaths, gruesome injuries, and emotional trauma that women experienced in the pre-*Roe* days due to the unavailability of safe and legal means to end pregnancies. These providers do not want to return to the past. That is why they persevere even in the face of harassment and violence, and despite the professional and personal toll that their work can take. They understand that women will not have the reproductive autonomy that this Court's decisions promise unless skilled doctors step up to render aid.

Abortion providers welcome and support safety regulations that promote the delivery of quality health care. Indeed, many conduct research to improve the already excellent safety record of abortion care. But they are deeply troubled by requirements of the sort at issue here, which are wholly disconnected from professional norms and do nothing to improve care.

II. Unfortunately, Texas's admitting privileges and ASC requirements are worse than pointless; they are counterproductive. They will needlessly harm the health of women who wish to end a pregnancy. Together, the requirements will have a devastating effect on access to safe abortion care by creating what amounts to a Catch-22: Physicians who specialize in abortion care are thwarted by the admitting privileges requirement, *not* because of any deficiency in their ability to perform safe abortions, but rather because their work is *so* safe that they do not admit enough patients to hospitals to qualify for privileges. Meanwhile, physicians who do substantial hospital-based work and spend just a portion of their time

providing abortion care in free-standing clinics are thwarted by the ASC requirement, which bars them from providing abortions except in costly special-purpose facilities that may be geographically distant from the rest of their practice.

With only a handful of providers left to meet the State's demand, women in Texas will face protracted waits for care and lengthy trips to get it. That means fewer women will be able to end pregnancies at the earliest stage, when the medical risks are lowest. And more women will tempt fate by turning to desperate measures. Even for women who manage to obtain treatment from one of the State's remaining providers, continuity of care will suffer. Inflicting such injuries in the name of women's health is perverse. This Court should reject this unconscionable threat to women's reproductive health.

ARGUMENT

I. ABORTION PROVIDERS ARE COMMITTED MEDICAL PROFESSIONALS WHO PRIORITIZE WOMEN'S HEALTH.

The regulations at issue in this case target one, and only one, group of doctors—those who provide abortions—and do so without valid justification. Texas has not defended its regulations as permissible measures to advance the State's interest in potential life, presumably because the regulations advance that interest only to the extent they preclude women who wish to end pregnancies from exercising their constitutional right to do so. Instead, Texas invokes its interest in protecting women's health. But that

justification rings hollow unless abortion providers endanger their patients' health in ways that plausibly warrant the State's extraordinary measures. Abortion providers pose no such dangers. Far from it.

While anti-abortion activists and their allies routinely seek to advance their cause by disparaging abortion providers as unqualified or unscrupulous,[3] the reality is very different. Physicians who provide abortions are highly trained professionals. Even in the face of frequent harassment and stifling regulations, they consistently deliver safe and compassionate care. Thanks in no small part to their skill and dedication, abortion is statistically a very low-risk medical procedure. Given providers' excellent safety record, the State's decision to single them out for disfavored regulatory treatment strongly suggests that the State's asserted health interest is pretextual. And pretext or not, the health interest is nowhere near sufficient to justify the magnitude of the burden the challenged requirements impose.

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[3] For instance, upon signing H.B. 2, then-Governor Rick Perry remarked that he heard "far too many stories ... about reckless doctors performing abortions in horrific conditions." *See* Rick Perry, Gov. of Tex., Gov. Perry's Remarks at House Bill 2 Signing, US State News (July 18, 2013). Echoing that sentiment, the State asserted (citing three aberrational incidents over a twenty-year period, all of which occurred outside of Texas) that "[t]he abortion profession has been known to attract practitioners who have inflicted grievous harms on their patients," thus justifying "preemptive actions to prevent these atrocities." Appellants' Reply Br., *Whole Woman's Health v. Lakey*, No. 14-50928, at 29-30 (5th Cir. 2014).

While each provider's biography is unique, the doctors whose stories are interspersed below are not anomalies. Hundreds of similar stories could be told and, indeed, Physicians for Reproductive Health has collected and shared many such accounts elsewhere. *See, e.g.*, Physicians for Reproductive Health, *Why I Provide*, http://tinyurl.com/o862xhc (last visited Dec. 30, 2015). Several overarching themes emerge from these accounts, all of which point to the folly of the regulations at issue here.

A. Providers are highly trained and have an excellent safety record.

In Texas (and many other States), the only people who can lawfully perform abortions are state-licensed physicians—*i.e.*, individuals whom the State has deemed qualified to practice medicine. *See* Tex. Health & Safety Code § 171.003; *see also* Tex. Occ. Code chs. 151-169 (detailing qualifications, professional standards, and disciplinary procedures for physicians). Abortion providers in Texas and elsewhere are thus graduates of accredited medical schools. They have passed formal licensing exams. They typically have completed residencies in specialties like obstetrics/gynecology (OB-GYN) or family medicine, going out of their way to choose residency programs that offer abortion-related training (many programs do not). Often (and increasingly), they have done multi-year post-residency fellowships in family planning. Many are affiliated with the country's most highly regarded educational institutions and medical facilities.

As the narratives in this brief vividly illustrate, any suggestion that "abortion doctors" are somehow less qualified or capable than other medical professionals is simply wrong. They are physicians like any other, with training and experience that includes abortion care but extends far beyond it. They have delivered babies, completed miscarriages, performed hysterectomies, prescribed contraceptives, and much more. As a technical matter, abortion tends to be one of the safest and most straightforward procedures they offer.

The professionalism of abortion providers is one reason why legal abortion today is exceptionally safe in both absolute and relative terms. There is less than a 0.23% risk of major complications following an abortion,[4] and the mortality rate from abortion-related complications is a miniscule 0.0006%, usually amounting to fewer than 10 fatalities per year nationwide.[5] In Texas, there have been *zero* fatalities among abortion patients in the five most recent years for which data is available.[6] By way of comparison, the mortality rate for colonoscopy is some 50 times higher

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[4] Ushma D. Upadhyay et al., *Incidence of Emergency Department Visits and Complications After Abortion*, 70 Obstetrics & Gynecology 175, 179 (2015).

[5] Elizabeth G. Raymond & David A. Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, 119 Obstetrics & Gynecology 215, 216 (2012).

[6] *See* Tex. Dep't of State Health Servs., *Vital Statistics Annual Reports*, http://tinyurl.com/p49vdyz (tabular data through 2013) (last visited Dec. 22, 2015).

than abortion,[7] and over the past five years, Texas has seen *85* reported deaths following dental procedures.[8] Moreover, the abortion complication and mortality rates just cited encompass all abortion procedures, including late-term ones, which, though still safe, carry additional risks. For early abortions (which account for the overwhelming majority of the procedures to which Texas's challenged regulations apply), the risk of major complications is even lower—0.06% for medical abortions,[9] and 0.05% for first trimester abortions by aspiration[10]—and the fatality rate is infinitesimal.

B. Providers are deeply committed to women's well-being.

Abortion-providing physicians could have chosen to take their medical careers in any number of directions. Many of the alternative paths available to them would have been more lucrative and certainly less professionally fraught. But they believe it is vital for

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[7] *See* Cynthia W. Ko et al., *Complications of Colonoscopy: Magnitude and Management*, 20 Gastrointestinal Endoscopy Clinics N. Am. 659, 659-71 (2010) (reporting 34.5 deaths per 100,000 procedures).

[8] Brooks Egerton, *Deadly Dentistry: Elusive Numbers*, Dallas Morning News (Dec. 9, 2015), http://tinyurl.com/pauxf8d.

[9] Kelly Cleland et al., *Significant Adverse Events and Outcomes After Medical Abortion*, 121 Obstetrics & Gynecology 166, 169 (2013).

[10] Tracy A. Weitz et al., *Safety of Aspiration Abortion Performed by Nurse Practitioners, Certified Nurse Midwives, and Physician Assistants Under a California Legal Waiver*, 103 Am. J. Pub. Health 454, 458 (2013).

women to receive competent and compassionate reproductive health care, including abortion. And they feel a responsibility to deliver that care personally, as Dr. Lisa Goldthwaite explains.

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Lisa Goldthwaite, M.D., M.P.H.

Dr. Goldthwaite is a Clinical Assistant Professor of OB-GYN at Stanford University. She provides generalist obstetrics and gynecology services in addition to family planning and abortion services.

I grew up in Eugene, Oregon, and I was raised in the United Church of Christ. Social justice was a huge part of my upbringing. My siblings and I have diverse careers—minister, artist, doctor—but we were all raised with a similar core ethic and we approach our careers with the same desire to help people and make the world a safer and better place.

After finishing my residency in OB-GYN, I decided to pursue a Family Planning Fellowship because I was committed to becoming an abortion provider and training others in this care. I now provide a wide range of OB-GYN care, including abortions.

I really love providing comprehensive reproductive health care to women. But for me, one of the most satisfying parts of my job is providing abortion care. Abortion is a foundational component of women's health. It's about women's lives. It's about what happens to our own bodies, as well as the kids and partners and others that we have obligations to. If women

can't determine if and when to be pregnant, then it may be impossible for them to control anything else in their lives. I have always been pro-choice, but, like many who identify as pro-choice, I probably had a naïve layer of judgment about abortion when I was younger. Through the various stories of the patients I meet, any judgment has vanished completely. There are unending reasons why a woman might seek an abortion. As a provider, I simply try to show up with an open mind, listen to my patients, and educate them about their safe and legal choices.

I could have easily chosen a comfortable, lucrative career practicing in a less controversial field of medicine. Everywhere I've practiced has had some degree of protesters, and stress. The protesters have even found and sent mail to my parents' address, where I haven't lived for over fifteen years. I don't like that I have to worry about the safety of my patients or spend time telling my family and friends not to worry about me. But being there for women who need abortions is immensely rewarding. I genuinely love what I do. I accept that this work comes with risks for me and judgment from others—after all, there's no other field of medicine that's so politicized—but I feel great pride in my work and I can't imagine doing anything else.

***

Dr. Goldthwaite's articulation of her reasons for becoming an abortion provider echoes this Court's recognition that a woman's ability to control her reproduction is central to her autonomy. *See, e.g.*, *Casey*, 505 U.S. at 856 ("The ability of women to participate equally in the economic and social life of the Nation

has been facilitated by their ability to control their reproductive lives."). She and her colleagues appreciate that when women are confronted with life's vagaries—unplanned pregnancy, severe birth defects, health complications, rape, spousal abuse, and more—some will make the deeply personal decision to obtain an abortion. They want those women to receive the respectful, conscientious and safe treatment they deserve.

Like Dr. Goldthwaite, many providers also place special emphasis on the social justice aspect of their work. While the demand for abortion cuts across all demographic groups, a disproportionate number of the women who seek care are in poverty or otherwise marginalized and underserved. They are in desperate need of reputable physicians willing to offer affordable and accessible reproductive health services. Many of the physicians who provide safe abortions to this population also endeavor to deliver more holistic care—health screenings and counseling, contraception, and more. Dr. Rachna Vanjani describes how she and her colleagues seek to meet the varied reproductive health needs of the women they serve.

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Rachna Vanjani, M.D.

Dr. Vanjani attended medical school at George Washington University. She is currently an OB-GYN in Contra Costa County, California participating in a national health service program.

From an early age, I wanted to be a physician who works with underserved communities to provide primary care and preventive medicine. At first I thought I would be a family physician, possibly working in global health practicing in a medically underserved part of the world. It became clear to me, though, that there are many areas of the United States that are, in fact, underserved—particularly when it comes to abortion. I became determined to remedy that. Working with underserved women is what I see as my life's work, and being an abortion provider is an integral part of that. I want to help women safely obtain the access and care they need to control their health and their lives. This is why I provide prenatal care, abortion services, contraception counseling, and other reproductive health services to underserved and marginalized women in Northern California.

I decided to become an OB-GYN because I believe that educating and providing reproductive health care can effect one of the most profound, positive changes in the life of a woman as well as in the lives of those around her. In the course of a morning, I can counsel a woman on terminating an unwanted pregnancy, provide prenatal care to another, and speak to a third about fertility treatments. The ability to give a woman the option to take control of her health and fertility, thereby empowering her to take control of her life, is not an obligation of my profession but a privilege that I am fortunate to fulfill.

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Some providers point to their religious faith, or to an ethic of service instilled in them from childhood, as a driving force behind their work.

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Willie Parker, M.D., M.P.H., M.Sc.

Dr. Parker attended medical school at the University of Iowa, completed residencies in OB-GYN and preventive medicine, and received a Masters in Public Health from Harvard University. A former official at the Centers for Disease Control, he currently practices in Mississippi and Alabama. Dr. Parker is a plaintiff-respondent in Jackson Women's Health Organization v. Currier, *a case challenging a restrictive Mississippi abortion law. (Mississippi's pending petition for certiorari in the case is No. 14-997.)*

Growing up in Alabama, religion was of deep importance to me. As a teenager, I was born again, preached in Baptist churches, and knocked on doors to share the word of God. In the first part of my career, I didn't do abortions; I considered them to be morally wrong. But I grew increasingly uncomfortable turning away women seeking abortions.

Reading a sermon by the Rev. Dr. Martin Luther King Jr. on the Good Samaritan challenged me to a deeper spiritual understanding. The Samaritan cared more about the well-being of the person needing help than about what might happen to him for stopping to give help. I wrestled with my conscience and realized that to show compassion to my patients, I needed to be able to provide abortions.

My belief in God tells me that the most important thing you can do for another human being is to help them in their time of need. That's why I have provided abortions full-time since 2009. I do not miss my easier path. I know that providing abortion care is just and noble and right.

***

Andrea Jackson, M.D., M.A.S.
Clinical Research

Dr. Jackson attended Harvard Medical School and completed her residency in OB-GYN at Brigham and Women's Hospital and Massachusetts General Hospital. She now practices in San Francisco.

As an OB-GYN, I wear many hats—I see patients, and I'm also an educator, training future doctors to provide abortion. I'm an abortion provider because I believe in the Golden Rule ("do unto others ...") and I believe in helping people.

I grew up in a modest household, so when I started looking at colleges I knew that whatever field I went into, it had to be something practical. My mom is a nurse, and I grew up watching her take care of people. I wasn't exactly sure what I wanted to do, but I wanted to be like my mom—the person everyone comes to for help.

My mom taught us the value in helping others, regardless of how much material wealth you have. I remember one Christmas, she explained to us that we didn't have the money for gifts that year. But instead of it being a sad day, the whole family went to the

homeless shelter, where we volunteered to serve Christmas dinner. I learned a profound lesson that day: You are always in a position to help others.

I had the opportunity to work abroad in Zimbabwe, where abortion is illegal. I saw many women who were suffering from botched, unsafe abortions—women who never recovered. The experience made me realize how important safe, legal abortion is in the United States, but also how tenuous that right can seem these days. As a doctor and an advocate, I'm determined to make sure that abortion remains accessible to everyone, regardless of where they live or how much money they make.

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Dr. Jackson's sobering encounter with the fallout from illicit abortion is not unique. Providers, especially those whose memories extend back to the pre-*Roe* era, frequently identify similar formative experiences. Dr. Wendy Chavkin, now a professor of public health and OB-GYN at Columbia University, has recounted a conversation she had with a leading New York OB-GYN shortly after *Roe*: "he was a devout and very conservative Catholic. But he'd seen women die of botched abortions resulting in gas gangrene of the uterus. He told me, 'Anyone who has ever seen a 13-year-old die like that has to support [legalized] abortion.'" Alex Ronin, *The First Legal Abortion Providers Tell Their Stories*, N.Y Mag. (Oct. 13, 2015), http://tinyurl.com/hle9x53 (quoting Dr. Chavkin). These physicians provide abortions to assure that no one else suffers a similar fate—a point Dr. D.B. amplifies.

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D.B., M.D.

Dr. B. attended Southwestern Medical School and did his residency at Louisiana State University at Shreveport. He currently has an OB-GYN practice and also works at the Hope Clinic providing abortion care. Dr. B. is involved in ongoing federal litigation over Louisiana abortion regulations, June Medical Services LLC v. Kliebert, *No. 14-CV-525 (M.D. La.). To protect his safety, the court in that case has shielded his identity from disclosure. Consistent with that determination, this brief refers to him only by his initials.*

I wasn't sure initially what kind of doctor I wanted to be. But when I got to my OB-GYN rotation, I loved that aspect of medicine. Delivering babies is very special. And I liked being able to combine internal medicine and surgery.

When I first came to Shreveport in the mid-1970s, even though abortion was technically legal, there were still no abortion services offered in this region. So I saw first-hand the horrible effects of what happens when quality abortion care is not available—awful infections and septic abortions. One patient stuck a hanger up her cervix and ruptured her membranes. Another did the same with a rubber catheter. Others saw back alley abortionists whose typical technique was to stick a probe into the uterus to rupture the membranes in order to induce an abortion. But if the woman didn't miscarry right away, she would get awful infections. One patient even tried to shoot the fetus with a gun. She missed the fetus, but hit her uterus, intestines, and liver, and had to have multiple

surgeries. It only takes one or two experiences like this to break your heart. And this was all at a time when abortion was legal; it just wasn't available in this region, and poor people couldn't afford to travel to receive good care from a doctor. I worry that if all of the restrictions on abortions and social pressures continue, it will be the same deal as it was back then.

When I finished my residency, I wasn't initially interested in performing abortions. But that same year the Hope Clinic opened in Shreveport. Originally they had recruited a general surgeon to work there, but he backed out so they asked me to assist. I thought it would be temporary, but no one else stepped forward, so I still work there two days per week.

The reason I do what I do is because I'm trying to help women have a better outcome because I believe they deserve it. That's what keeps me going even though providing abortion care is really stressful for me, my wife, and my family. I certainly don't want to go back to what it used to be.

(Dr. B.'s story is continued in Part II.)

C. Providers persevere even in the face of adversity.

Abortion providers often have their dedication tested in extreme ways. The vast majority of abortion clinics experience some form of anti-abortion harassment. *See* Rachel K. Jones & Kathryn Kooistra, *Abortion Incidence and Access to Services in the United States, 2008*, 43 Persp. on Sexual & Reproductive

Health 41, 48 (2011). Many physicians have faced chilling intimidation—hate mail, death threats, stalking, and vandalism. Most have discovered personal information and photos of themselves and their family members posted on anti-choice websites. After discovering a picture of her young daughter on such a website, one doctor wrote:

> As a mother, it is especially difficult to shoulder this risk as a cost of doing my job. When I am out in public, I remain intensely aware of my surroundings: Every time I turn the ignition key in my car, there's a fraction of a second of panic that someone may have planted a bomb. On public transit, if strangers' gazes linger for more than a few seconds, I wonder if they recognize me and if their intentions are sinister. I fear for the safety of my child. I worry that protesters may someday show up at her day care, focused on hurting her as a way to punish me. ... There is no better way to intimidate and incite fear than to target a family member, especially a child. The message is unambiguous: I'm being watched, and so is my daughter.

Diane J. Horvath-Cosper, *Being a Doctor Who Performs Abortions Means You Always Fear Your Life Is in Danger*, Wash. Post (Oct. 29, 2015), http://tinyurl.com/pfejw9n.

And, tragically, providers know that the possibility of violence is all too real. The recent shooting at a Planned Parenthood clinic in Colorado is just the latest reminder. Since 1993, there have been 11 murders and 26 attempted murders attributable to anti-abortion violence. *See* Nat'l Abortion Fed'n, *Violence Statistics & History*, http://tinyurl.com/pfmdt89 (last visited Dec. 30, 2015). Dr. Douglas Laube elaborates upon some of the challenges providers face, and his experience exemplifies providers' resolve to carry on.

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Douglas Laube, M.D., M.Ed.

Dr. Laube has been an OB-GYN for over 40 years. He is a past President of the American College of Obstetricians and Gynecologists and former Chair of the OB-GYN Department at the University of Wisconsin. Earlier in his career he served as a naval doctor at Marine Corps Base Quantico.

Becoming a physician was part of how I grew up. My father was a surgeon, and I followed in his footsteps. I specialized in OB-GYN because I liked the preventive medicine aspect, as well as the surgical aspect of OB-GYN. When I was in medical school, I witnessed the death of a 17-year-old girl from a septic abortion. It had a real impact on me. *Roe* was decided shortly after my residency, and within two months we had begun providing abortion care at the University of Iowa, and we built abortion training into the residency.

Being an abortion provider means always being on alert for potential danger to yourself and your patients. One story sticks with me in particular. Back in the late 1980s, an anti-choice group from Wichita set its sights on the University of Iowa clinic. I was in the middle of a procedure when I heard the banging. A nurse saw the protesters trying to break down the clinic doors with a telephone pole and called security. As I finished the procedure, my patient looked at me imploringly and grabbed my arm. "You can't leave now." she pleaded. By then, the protesters had broken the glass door, but had been stopped and apprehended by security guards. I assured my scared patient that no one was going anywhere. And I continued providing abortions.

When my children were young, I occasionally worried that I was putting them in jeopardy by being an abortion provider. This is common for providers with young children. I'm 71 now, and my kids are grown. I've recommitted myself to this work because it is worth fighting for. Even if you rule that these restrictions are constitutional, and women are unable to access quality care from trained physicians, women will still have abortions. We've come so far in medical science, and we can't afford to go backwards.

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That physicians who provide abortions persevere despite the risks and the stresses is a testament to the seriousness with which they take their work. Providers do not put themselves in harm's way to deliver indifferent, second-rate care. They give it their all.

D. Providers respect the need for regulation and scrupulously comply with their regulatory obligations.

None of this is to suggest that abortion providers believe they should be immune from regulation. They make peace with the fact that they are this country's most heavily regulated and closely scrutinized group of medical professionals. They recognize that this Court's precedents allow properly tailored measures to advance States' interest in potential life. And they appreciate that State efforts to regulate the practice of medicine can play an important role in protecting patient health. Indeed, Dr. B. was involved in commenting on Louisiana's first set of licensing regulations on abortion clinics in the 1980s. Those initial regulations, he explained, were straightforward and made sense: They codified what good medical practice required.

The vast majority of abortion providers scrupulously comply with their many regulatory obligations, and they have little sympathy for the rare bad apple who does not. *Cf. Roe*, 410 U.S. at 166 ("If an individual practitioner abuses the privilege of exercising proper medical judgment, the usual remedies, judicial and intra-professional, are available."). But providers chafe at regulations of the sort at issue here, which single them out in the name of protecting health and saddle them with vexatious requirements that simply don't make sense from a medical perspective. While States no doubt have "considerable [regulatory] discretion," that "discretion does not permit [them] to adopt abortion regulations that depart from accepted medical practice." *Simopoulos v. Virginia*, 462 U.S.

506, 516 (1983); *see also Akron v. Akron Ctr. for Reproductive Health, Inc.*, 462 U.S. 416, 437-38 (1983) (striking an ordinance that "imposed a heavy, and unnecessary, burden" and was out of step with "'present medical knowledge'") (quoting *Roe*, 410 U.S. at 163).[11] The admitting privileges and ASC regulations fall squarely in that category.

The oddities of Texas's regulations are glaring. The State bars a physician from performing even the lowest risk early abortion procedures—including non-surgical medication abortion—except in an ASC and only if she first obtains hospital admitting privileges. Yet if the *very same* physician decides to perform any number of riskier non-abortion procedures, she is free to do so in a non-ASC setting and without admitting privileges. *Cf. Doe v. Bolton*, 410 U.S. 179, 199 (1973) (striking a law requiring a doctor to obtain assent from two consulting physicians before performing an abortion—a requirement applicable to "no other voluntary medical or surgical procedure" in the State"). That double standard makes it difficult to see the challenged requirements as genuine health regulations at all, much less as ones that have been "tailored to ... recognized state interests." *Roe*, 410 U.S. at 165.

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[11] While *Casey* later overruled certain portions of *Akron*, it left undisturbed the principle that a "State's discretion to regulate on th[e] basis [of maternal health] does not ... permit it to adopt abortion regulations that depart from accepted medical practice." 462 U.S. at 431.

II. TEXAS'S HEAVY-HANDED REGULATION OF ABORTION PROVIDERS WILL HARM WOMEN.

The problem with Texas's admitting privileges and ASC requirements is not just that they are medically unjustified; it is that they will harm the very people they supposedly protect by making it immensely more difficult for women to obtain good reproductive care. Because these regulations "impose a real health risk," they cannot stand. *Casey*, 505 U.S. at 885-86 (upholding a 24-hour waiting period requirement only after determining that it did *not* "create any appreciable health risk"). States should not be permitted to outlaw the common, long-accepted, and medically sound practice of having trained physicians, whatever their admitting privilege status, provide abortion care in non-ASC clinics. *Cf. Planned Parenthood of Cent. Mo. v. Danforth*, 428 U.S. 52, 78-79 (1976) (rejecting a ban on "the most commonly used" method of terminating pregnancies after the first trimester).

A. Texas's regulations would severely restrict women's access to trained providers.

The regulations at issue here pack an insidious one-two punch. The admitting privileges requirement serves as a major barrier for physicians who specialize in abortion care. Most such physicians do not qualify for admitting privileges under hospitals' usual criteria—*not* because of any deficiency in their ability to perform safe abortions, but rather precisely because abortion is so safe that they almost never have

occasion to admit their patients to a hospital. The ASC requirement, meanwhile, poses significant difficulties for all providers, but it is especially problematic for physicians who offer abortion care as one part of a broader medical practice. While some of these physicians may do enough hospital-based work to qualify for admitting privileges, they usually provide abortions in a stand-alone clinic. Requiring them to use ASCs rather than other clinical facilities is a severe impediment, both because ASCs are prohibitively expensive to build and maintain and also because they will tend to be more geographically removed from the rest of a physician's practice.[12]

The upshot is that the admitting privileges and ASC requirements together would result in shuttering three-quarters of the abortion facilities present in Texas before passage of H.B. 2. And this in a State where abortion and other family planning services are already undersupplied. If these regulations are upheld, Texas will have taken a decisive step toward becoming a place where a woman's choice "exists in theory but not in fact." *Casey*, 505 U.S. at 872. The physicians profiled below have witnessed the impact of similar laws first hand.

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[12] Due to a combination of historical factors, state laws, and institutional rules, most hospitals and surgical centers do not permit abortions except in rare circumstances. Thus, as a practical matter, Texas's ASC requirement means that specialized abortion-oriented ASCs are the only places where abortions can be performed.

Herbert Hodes, M.D. & Traci Nauser, M.D.

Dr. Hodes and Dr. Nauser are a father and daughter team who operate the Center for Women's Health in Overland Park, Kansas, where they provide a full range of reproductive services, including abortion. As in Texas, abortion in Kansas is heavily regulated (including facility licensing and admitting privileges requirements that are currently enjoined), and the State has a history of harassment and violence against providers.

Dr. Hodes: I received my medical training and did my OB-GYN residency at the University of Kansas Medical Center in the early 1970s where I saw first-hand what happens when women are not able to access legal abortion. Back then we had wards of sick patients who'd had criminal abortion procedures. I performed hysterectomies on young women who were septic; it was the only way to save their lives. I saw that women would always try to find a way to end an unwanted pregnancy, and once it became legal, I wanted to make sure it was done properly.

Being an abortion provider has altered the way I live my life. I worry about violence, and about my family being harmed because of what I do. When Traci (Dr. Nauser) decided to go to medical school I was worried that she wouldn't get accepted because of what I do.

TRAP [targeted regulation of abortion providers] laws do not advance women's health; they are purely punitive. In Kansas, the State has imposed admitting

privileges and facility licensing requirements reminiscent of those in Texas, which have since been preliminarily enjoined. Such requirements are medically unjustified and make it that much more difficult for good providers to deliver the care their patients need. It is extremely rare that I've had to send a patient to the hospital for abortion-related complications. Hospitals will see a patient regardless of whether or not her doctor has admitting privileges. There are cataract and orthopedic surgeons who travel around the country performing surgeries that are far riskier than abortions. Requiring surgeons to have admitting privileges is unheard of, except for abortion providers. Similarly, our current office is not an ASC, and there's no reason it should be. Complying with an ASC requirement would be hugely difficult and expensive and would do nothing to help our patients.

If access to abortion is curtailed, women with money will travel great distances to receive safe abortions. But poor women will buy drugs online, or induce abortions in other ways, or go to Mexico if they're near the border. There will be medical complications. Women will die.

Dr. Nauser: Growing up as the adopted daughter of an OB-GYN physician who provides abortions, I have experienced harassment first-hand. But I always knew that I wanted to become an amazing, skilled, and well-respected physician like my father, who provided complete and compassionate care for women no matter what their reproductive health care needs were. I received my medical degree from the University of Missouri Kansas City School of Medicine's combined six-year B.A./M.D. program, and did

a residency in OB-GYN there as well at Truman Medical Center and St. Luke's Hospital in Kansas City. Now my father, Dr. Hodes, and I provide a full range of obstetrical and gynecological services. To name a few, we deliver babies, provide prenatal care, contraceptive care, infertility treatments, office-based gynecological surgeries, hospital-based surgeries such as hysterectomies, and we perform elective and medically indicated terminations up to 22 weeks. Terminations form only a fraction of our practice. Many of our patients will never need a termination, but they choose us because we provide women safe, skilled, compassionate, nonjudgmental complete reproductive healthcare. Many patients who initially came to us for a termination in one pregnancy have later returned to us in another pregnancy for prenatal care and to deliver their baby. Helping a woman during a difficult time in her life and then helping her welcome a child later is an extremely rewarding and gratifying privilege.

TRAP laws like the admitting privileges and ASC requirements in Texas do not advance women's health. They actually increase risks and cause harm. For example, an office-based D&C procedure for an extremely heavy menstrual cycle, a miscarriage, or endometrial biopsy can be done with simple surgical counseling and consent, and the procedure takes two to three minutes. Once the patient is deemed clinically suitable for discharge (usually 10-20 minutes later), she can go home. However, for a surgically-identical D&C procedure for an abortion, per the law everything is different. Just to name a few examples, the procedure room must be a certain size and temperature, a registered nurse must be used, the woman

must go to a specific recovery room of a specific size for no less than two hours, and she must receive specific follow up. All four of those procedures are surgically identical. Yet only one faces additional regulatory hurdles that do not do anything to advance women's health and safety.

If it becomes too difficult for women—especially low-income women who can't travel to receive care because they don't have the funds, or have other children to care for, or can't take time off from their jobs—they're going to turn to underground, illegal drugs and unsafe, unqualified providers. Without access to legal abortion care by trained providers, women will go back to being harmed or dying from botched abortions as in the pre-Roe days.

When Dr. Hodes retires, it will be difficult for me to find a new partner because I provide terminations as part of a private OB-GYN practice. But I can't stop providing terminations. Women need someone willing to provide the safest abortion care available. How can you turn someone away when you're an OB-GYN, trained to take care of a woman completely? The stigma, fear, and politics associated with abortion care are the reasons why most OB-GYNs won't do it, but it's unacceptable. We're trained to take care of women, not partially take care of women.

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D.B., M.D. (continued from Section I.B)

Dr. B. has an OB-GYN practice and provides abortions in Louisiana, which (among many other regulations) has an admitting privileges requirement that is currently enjoined.

In addition to my work at the Hope Clinic in Shreveport, I also have a private full-service OB-GYN practice, one of the largest in this area, where I do not perform abortions. I'm one of the very few doctors to do both. It's hard to relate to people how difficult it is to be a physician who maintains a private practice in OB-GYN and also performs abortions. People marginalize you, discriminate against you, harass you. And that's one of the reasons why you end up with doctors having to choose between doing routine OB-GYN care or abortion care. At one point we had as many as seven doctors providing abortion care in the Shreveport area, but one by one they stopped.

As a result, most doctors who provide abortions do not have admitting privileges—they have been basically forced to specialize, and doctors who only provide abortions don't use the hospital enough to get admitting privileges. Louisiana passed an admitting privileges law like the one in Texas, but it is currently preliminarily enjoined. At the time it went into effect, I was the only provider in the State with admitting privileges. My colleague at the Hope Clinic, an excellent and experienced physician, was unable to obtain admitting privileges from any of our three local hospitals. If the admitting privileges law goes into effect, I would be the only provider in the Shreveport area.

And if Louisiana imposes an ASC requirement (something I'm sure they'd do if the Texas one is upheld), the situation will be even more dire. Complying with an ASC requirement would be extremely burdensome—maybe even financially or logistically impossible. The combination of these laws would cripple us.

Lack of access to abortion services has negative health consequences for women. If women have to wait longer to get an abortion, they will be further along in their pregnancy and are more likely to have a complication. It's safest to do abortions in the first trimester and, if possible, the first half of the first trimester. Already people seem to be traveling farther to get an abortion. Although a majority of our patients still come from around northern Louisiana, we're beginning to see patients from Texas at the clinic. We also see patients from Mississippi and southern Louisiana. The irony of the admitting privileges law is that patients are now traveling 180 or more miles to get an abortion. What good do admitting privileges do if they go home and have a complication there?

I don't think I would continue to provide abortions if I were the only one doing so in the Shreveport area. Already an anti-abortion group from outside Shreveport protested outside my private practice. They told one of my patients, the mother of a one-week old, as she was coming into my building that I would kill her baby when she reached my office. They left posters and flyers all over the neighborhood where I live urging people to attack me on religious grounds. I'm fearful that if I'm the only provider, I will become the primary target, and they will treat me like Dr. Tiller [who was murdered in Kansas in 2009].

But for now I will continue to provide abortion care. The reason I do what I do is because I'm trying to help women have a better outcome because I believe they deserve it.

B. Access restrictions harm women's health.

Women's health suffers when the law impedes access to safe abortion services. The provider narratives identify at least three ways in which the precipitous decline in available abortion facilities and providers in Texas will endanger women's health.

First, women's care will be significantly delayed. With fewer clinics and physicians to meet a demand for care that already strains the capacity of the State's providers, women will inevitably have to wait longer for appointments and procedures. Moreover, women will have to travel much farther on average to reach providers, which will also postpone care.

As a result of distance and delays, fewer women will be able to end their pregnancies at the earliest stage, when health risks are lowest. While abortions further in pregnancy remain very safe as medical procedures go, they are more invasive, take a greater physical and emotional toll on the patient, and have a higher complication rate than early terminations—a reality this Court has long recognized. *See Doe*, 410 U.S. at 198 ("Time, of course, is critical in abortion. Risks during the first trimester of pregnancy are admittedly lower than during later months.").

Second, women will increasingly resort to riskier measures to end pregnancies. History and experience teach a clear lesson: When safe abortion care becomes more difficult to access, injuries and death from unsafe abortions rise.[13] Some women will seek out illegal providers whose services may fall tragically short of prevailing standards of care. Others will try to self-induce, turning to black-market drugs, unregulated herbs, self-surgery, and worse. Even before the enactment of the admitting privileges and ASC requirements, Texas's Rio Grande Valley—a place where women have limited access to legal abortion care—had one of the country's highest rates of self-induced abortion. *See* Daniel Grossman et al., *The Public Health Threat of Anti-Abortion Legislation*, 89 Contraception 73, 73-74 (2014).

Third, even for women who manage to obtain treatment at one of the State's remaining facilities, continuity of care will be disrupted. These women will more often be farther from home, being cared for by physicians unfamiliar to them. Should a complication arise during or immediately after the procedure, they will not be able to turn to their usual doctors and support networks for assistance. Should a complication arise later, they will have greater difficulty following up with the physician who treated them. And even when the procedure goes smoothly (as it usually will), providers will have fewer opportunities to address pa-

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[13] International data on this point is especially striking: When South Africa liberalized its abortion laws, it saw a 91% drop in abortion-related deaths. *See* Guttmacher Inst., *Facts on Induced Abortion Worldwide* (Jan. 2012), http://tinyurl.com/z25op2p.

tients' broader reproductive health and family planning needs. Dr. Sarah Wallett elaborates on these points.

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Sarah Wallett, M.D., M.P.H.

Dr. Wallett teaches abortion care and provides abortion and other gynecological services in Kentucky—another State with onerous regulations and limited abortion access.

I grew up in Lexington, South Carolina. My dad works in business and my mom is a school teacher. I was raised Lutheran. My family went to church regularly, said prayers before meals, and most of all believed we were duty-bound to help people in need.

I don't know exactly when I decided to become an abortion provider. Growing up we never talked about abortion in my family or at my school. If someone had asked me, I would have said abortion is bad because that was the sense I got growing up in the South. But when I got to college, I began thinking more deeply about the issue and what it meant to women. And in medical school, when I decided to be an OB-GYN and take care of women, it became clear to me that being able to provide abortion care was a part of this.

My goal as an abortion provider is to create a nonjudgmental space for women to make their decision and to provide the best quality medical care. The longer I have worked in this area, taking care of patients in so many different situations with different

responsibilities, medical histories, or family structures, the more I recognize that it isn't my role to have a say in their decision. I feel really good providing this care because I know I'm helping these women when they need it. That's my calling as a doctor.

After finishing my residency and a two-year family planning fellowship at the University of Michigan, I decided to move back to the South and took a position in Kentucky teaching family planning and abortion care. I provide general gynecological care for women, but I do not provide abortion care because Kentucky law prohibits the provision of abortion at state facilities unless it is to save the life of a woman. This really impedes my ability to teach students and residents how to deliver abortion care.

I'm trying to figure out a way to provide abortion care more regularly now because it is clear that my patients don't have access. There is only one full-service abortion clinic in all of Kentucky, and it's a 3-4 hour drive from eastern Kentucky, one of the most impoverished areas in the United States. I often have to tell my patients that I can't take care of them because of legal restrictions. This is heartbreaking since I have the skills and the facilities to provide this care.

Limited access to abortion in Kentucky leads to long waiting lists at the one full-service clinic. It often takes several weeks before a patient can get an appointment. These weeks matter. Sometimes what could have been an earlier medical abortion becomes a later surgical abortion, which is riskier for the woman's health.

I recently had a patient who came to see me in my general clinic. She had been raped and was pregnant. She had Medicaid, which in Kentucky will pay for abortion in the case of rape, but I couldn't provide her care where I work because of state law, and the abortion clinic does not take insurance. After trying in vain to figure out how to get care, she ended up traveling out of state several weeks later to have a surgical abortion, paying out of pocket. It was horrible for her. And weeks earlier she was sitting in my office, having made the decision that she did not want to continue the pregnancy. I am a very well-trained physician. I did an extra two years of work so that I know the most I can about abortion. I could have easily cared for her at that moment, providing her with a medical abortion. It was just state laws severely restricting where abortions can be performed that prevented me from continuing to care for that patient, and providing her with the earliest, safest abortion.

So many of the restrictions in place right now across the country from a medical perspective are clearly not about providing good medical care for women. For example, there's no medical reason for a woman to be required to take abortion medications at a surgical center. These regulations are about taking away access, and taking away access doesn't make abortion not happen. Women will have abortions, and we can make them safe by providing access to good medical care, or we can create so many obstacles that women will find a way to have them without safe good medical care.

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If a woman's right "to retain the ultimate control over her destiny and her body" is to have the "real substance" that this Court's decisions promise, *Casey*, 505 U.S. at 869, then surely regulations that so flagrantly limit access and imperil health—as Texas's admitting privileges and ASC requirements do— cannot stand.

CONCLUSION

For these reasons, the decision of Court of Appeals should be reversed.

Respectfully submitted,

Thomas M. Bondy
Susannah Landes Weaver
ORRICK, HERRINGTON & SUTCLIFFE LLP
1152 15th Street, NW
Washington, DC 20005

E. Joshua Rosenkranz
Counsel of Record
Sarah M. Sternlieb
ORRICK, HERRINGTON & SUTCLIFFE LLP
51 West 52nd Street
New York, NY 10019
(212) 506-5000
jrosenkranz@orrick.com

January 4, 2016